General

Guideline Title

Screening for speech and language delay and disorders in children aged 5 years or younger: U.S. Preventive Services Task Force recommendation statement.

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for speech and language delay and disorders in children aged 5 years or younger: U.S. Preventive Services Task Force recommendation statement. Pediatrics. 2015 Aug;136(2):e474-81. [22 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for speech and language delay in preschool children: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006. 10 p. [29 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the levels of certainty regarding net benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendation and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for speech and language delay and disorders in children aged 5 years or younger (I statement).

Clinical Considerations

Patient Population Under Consideration

This recommendation applies only to asymptomatic children whose parents or clinicians do not have specific concerns about their speech, language, hearing, or development. It does not apply to children whose parents or clinicians raise those concerns; these children should undergo evaluation and, if needed, treatment.

This recommendation discusses the identification and treatment of "primary" speech and language delays and disorders (i.e., in children who have

not been previously identified with another disorder or disability that may cause speech or language impairment).

Suggestions for Practice Regarding the I Statement

Potential Preventable Burden

Information about the prevalence of speech and language delays and disorders in young children in the United States is limited. In 2007, ~2.6% of children ages 3 to 5 years received services for speech and language disabilities under the Individuals with Disabilities Education Act (IDEA).

Childhood speech and language disorders include a broad set of disorders with heterogeneous outcomes. Information about the natural history of these disorders is limited, because most affected children receive at least some type of intervention. However, there is some evidence that young children with speech and language delay may be at increased risk of language-based learning disabilities.

Potential Harms

The potential harms of screening and interventions for speech and language disorders in young children in primary care include the time, effort, and anxiety associated with further testing after a positive screen, as well as the potential detriments associated with diagnostic labeling. However, the USPSTF found no studies on these harms.

Current Practice

Surveillance or screening for speech and language disorders is commonly recommended as part of routine developmental surveillance and screening in primary care settings (i.e., during well-child visits). In practice, however, such screening is not universal. The previous evidence review found that 55% of parents reported that their toddler did not receive any type of developmental assessment at their well-child visit, and 30% of parents reported that their child's health care provider had not discussed with them how their child communicates. In a 2009 study, approximately half of responding pediatricians reported that they "always or almost always" use a standardized screening tool to detect developmental problems in young children; ~40% of respondents reported using the Ages and Stages Questionnaire (ASQ). The USPSTF distinguishes between screening in primary care settings and diagnostic testing, which may occur in other settings.

Assessment of Risk

On the basis of a review of 31 cohort studies, several risk factors have been reported to be associated with speech and language delay and disorders, including male sex, family history of speech and language impairment, low parental educational level, and perinatal risk factors (e.g., prematurity, low birth weight, and birth difficulties).

Screening Tests

The USPSTF found inadequate evidence on specific screening tests for use in primary care. Widely used screening tests in the United States include the ASQ, the Language Development Survey (LDS), and the MacArthur-Bates Communicative Development Inventory (CDI).

Interventions

Interventions for childhood speech and language disorders vary widely and can include speech-language therapy sessions and assistive technology (if indicated). Interventions are commonly individualized to each child's specific pattern of symptoms, needs, interests, personality, and learning style. Treatment plans also incorporate the priorities of the child, parents, and/or teachers. Speech-language therapy may take place in various settings, such as speech and language specialty clinics, the school or classroom, and the home. Therapy may be administered on an individual basis and/or in groups, and may be child-centered and/or include peer and family components. Therapists may be speech-language pathologists, educators, or parents. The duration and intensity of the intervention depend on the severity of the speech or language disorder and the child's progress in meeting therapy goals.

Other Approaches to Prevention

The USPSTF recommends screening for hearing loss in all newborn infants (B recommendation). The USPSTF is developing a recommendation on screening for autism spectrum disorder in young children. These recommendations are available on the USPSTF Web site (www.uspreventiveservicestaskforce.org).

Useful Resources

All states have designated programs that offer evaluation and intervention services to children ages 0 to 5 years. IDEA is a law that ensures early intervention, special education, and related services for children with disabilities in the United States. Infants and toddlers (birth to age 2 years) with disabilities and their families may receive early intervention services under IDEA part C, whereas children and adolescents (ages 3 to 21 years)

may receive special education and related services under IDEA part B.

Definitions

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of USPSTF Recommendation Statement (see the "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies

Level of Certainty	Description
	• Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Speech and language delay and disorders

Guideline Category

Prevention

Screening

Clinical Specialty

Family Practice

Pediatrics

Preventive Medicine

Speech-Language Pathology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Physician Assistants

Physicians

Speech-Language Pathologists

Guideline Objective(s)

To summarize the U.S. Preventive Services Task Force (USPSTF) recommendation on screening for speech and language delay in preschool children and the supporting evidence

Target Population

Asymptomatic children aged 5 years or younger whose parents or clinicians do not have specific concerns about their speech, language, hearing or development

Interventions and Practices Considered

Screening for speech and language delay and disorders in children aged 5 years or younger

Major Outcomes Considered

- Key Question 1: Does screening for speech and language delays or disorders lead to improved speech and language as well as improved outcomes in domains other than speech and language?
- Key Question 2: Do screening evaluations in the primary care setting accurately identify children for diagnostic evaluation and interventions?
- Key Question 2a: What is the accuracy of these screening techniques, and does it vary by age, cultural/linguistic background, whether the screening is conducted in a child's native language, or how the screening is administered (i.e., parent report, parent interview, or direct assessment of child by professional)?
- Key Question 2b: What are the optimal ages and frequency for screening?
- Key Question 2c: Is selective screening based on risk factors more effective than unselected, general-population screening?
- Key Question 2d: Does the accuracy of selective screening vary based on risk factors? Is the accuracy of screening different for children with an inherent language disorder compared with children whose language delay is due to environmental factors?
- Key Question 3: What are the adverse effects of screening for speech and language delays or disorders?
- Key Question 4: Does surveillance (active monitoring) by primary care clinicians play a role in accurately identifying children for diagnostic evaluations and interventions?
- Key Question 5: Do interventions for speech and language delays improve speech and language outcomes?
- Key Question 6: Do interventions for speech and language delays or disorders improve other outcomes, such as academic achievement, behavioral competence, socioemotional development, or health outcomes, such as quality of life?
- Key Question 7: What are the adverse effects of interventions for speech and language delays or disorders (e.g., time, stress, and stigma)?

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review and full report was prepared by the RTI International–University of North Carolina Evidence-based Practice Center (EPC) for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Search Strategies

Following the USPSTF Procedure Manual (see "Availability of Companion Documents" field), investigators developed an analytic framework (see Figure 1 in the full report), list of key questions, and supporting contextual questions. They searched Medline (via PubMed), the Cochrane Library, PsycINFO, and Cumulative Index to Nursing and Allied Health Literature (CINAHL) for English language articles published from January 1, 2004, through July 20, 2014. They conducted targeted searches for unpublished literature in ClinicalTrials.gov. Appendix A in the full report documents the search strategy. To supplement electronic searches, they reviewed reference lists of pertinent review articles and included studies.

Investigators used a PICOTS (populations, interventions, comparators, outcomes, timing, settings, and study designs) approach to identify studies that met inclusion and exclusion criteria that they developed for each key question (see Appendices B and C in the full report). Two reviewers independently applied inclusion and exclusion criteria to all studies in the 2006 review and to all new studies from their update searches.

See Appendix A in the full report for a summary of the evidence search and selection.

Number of Source Documents

115 studies (119 articles) were included in the systematic review (including 26 poor quality studies). See the PRISMA diagram (Figure 2) in the full report (see the "Availability of Companion Documents" field).

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Two reviewers independently rated the quality of each study based on U.S. Preventive Services Task Force (USPSTF) guidelines as good, fair, or poor. See the "Description of the Methods Used to Analyze the Evidence" field for further information.

Methods Used to Analyze the Evidence

Meta-Analysis of Randomized Controlled Trials

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review and full report was prepared by the RTI International–University of North Carolina Evidence-based Practice Center (EPC) for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Methods

An investigator abstracted evidence from included full-text articles for each key question; a second investigator checked and confirmed each abstraction. They also checked for errors in the abstractions of studies in the 2006 review. Two reviewers independently rated the quality of each study based on USPSTF guidelines as good, fair, or poor (see Appendix D in the full report); they resolved discrepancies by discussion. The reviewers reassessed the quality rating of studies in the 2006 review to ensure that they met current criteria. If 1 reviewer disagreed with this earlier assessment, they rerated the quality of that study through dual review.

The investigators abstracted accuracy statistics when available from screening studies. When accuracy statistics were not provided, they calculated sensitivity, specificity, prevalence, positive and negative predictive values, positive and negative likelihood ratios (LRs), and 95% confidence intervals (CIs) for sensitivity and specificity (see Appendix E in the full report).

The investigators evaluated applicability to US primary care populations based on demographics, coexisting conditions, representativeness of the population, study refusal rate, severity of the delay, and recruitment source and applicability of the intervention/screening (i.e., how well the clinical experience is liable to be reproduced in other settings).

Methods Used to Formulate the Recommendations

Balance Sheets

Description of Methods Used to Formulate the Recommendations

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A, B, C, D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the USPSTF after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the USPSTF seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the USPSTF considers indirect evidence. To guide its selection of indirect evidence, the USPSTF constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the USPSTF process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the USPSTF's overall assessment of evidence was described as good, fair, or poor. The USPSTF realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term certainty will now be used to describe the USPSTF's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the USPSTF makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The USPSTF must consider differences between the

general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The USPSTF considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the USPSTF assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The USPSTF would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The USPSTF would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the USPSTF to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, Guirguis-Blake J, LeFevre M, Harris R, Petitti D, U.S. Preventive Services Task Force. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147(12):871-875. [5 references].

I Statements

For I statements, the USPSTF has a new plan to commission its Evidence-based Practice Centers (EPC) to collect information in 4 domains pertinent to clinical decisions about prevention and to report this information routinely. This plan is described in the paper: Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. *Ann Intern Med*. 2009;150:199-205. Available at: www.annals.org

The first domain is potential preventable burden of suffering from the condition. When evidence is insufficient, provision of an intervention designed to prevent a serious condition (such as dementia) might be viewed more favorably than provision of a service designed to prevent a condition that does not cause as much suffering (such as rash). The USPSTF recognized that "burden of suffering" is subjective and involves judgment. In clinical settings, it should be informed by patient values and concerns.

The second domain is potential harm of the intervention. When evidence is insufficient, an intervention with a large potential for harm (such as major surgery) might be viewed less favorably than an intervention with a small potential for harm (such as advice to watch less television). The USPSTF again acknowledges the subjective nature and the difficulty of assessing potential harms: for example, how bad is a "mild" stroke?

The third domain is cost—not just monetary cost, but opportunity cost, in particular the amount of time a provider spends to provide the service, the amount of time the patient spends to partake of it, and the benefits that might derive from alternative uses of the time or money for patients, clinicians, or systems. Consideration of clinician time is especially important for preventive services with only insufficient evidence because providing them could "crowd out" provision of preventive services with proven value, services for conditions that require immediate action, or services more desired by the patient. For example, a decision to routinely inspect the skin could take up the time available to discuss smoking cessation, or to address an acute problem or a minor injury that the patient considers important.

The fourth domain is current practice. This domain was chosen because it is important to clinicians for at least 2 reasons. Clinicians justifiably fear that not doing something that is done on a widespread basis in the community may lead to litigation. More important, addressing patient expectations is a crucial part of the clinician–patient relationship in terms of building trust and developing a collaborative therapeutic relationship. The consequences of not providing a service that is neither widely available nor widely used are less serious than not providing a service accepted by the medical profession and thus expected by patients. Furthermore, ingrained care practices are difficult to change, and efforts should preferentially be directed to changing those practices for which the evidence to support change is compelling.

Although the reviewers did not explicitly recognize it when these domains were chosen, the domains all involve consideration of the potential consequences—for patients, clinicians, and systems—of providing or not providing a service. Others writing about medical decision making in the face of uncertainty have suggested that the consequences of action or inaction should play a prominent role in decisions.

Rating Scheme for the Strength of the Recommendations

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

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C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of USPSTF Recommendation Statement (see the "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes

Level of Certainty	Description More information may allow an estimation of effects on health outcomes.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Peer Review

Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality send the draft evidence review to 4 to 6 external experts and to Federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. The draft evidence review is also posted on the USPSTF Web site for public comment. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment among reviewers representing professional societies, voluntary organizations, and Federal agencies, as well as posted on the USPSTF Web site for public comment. These comments are discussed before the final recommendations are confirmed.

Response to Public Comment

A draft version of this recommendation statement was posted on the USPSTF Web site from November 18 to December 15, 2014. In response to public comment, the USPSTF clarified that this recommendation applies only to asymptomatic children whose parents or clinicians do not have specific concerns about their speech, language, hearing, or development. The USPSTF also emphasized that this recommendation applies only to screening in primary care settings, and it noted the distinction between screening in primary care settings and diagnostic testing, which may occur in other settings. The USPSTF also noted that this recommendation does not evaluate screening for autism spectrum disorder, which the Task Force will address in a separate recommendation statement. The USPSTF also called for research on socioeconomic and other factors associated with risks, assessment, and management of speech and language delay and disorders in children.

Comparison with Guidelines from Other Groups

Recommendations for screening from the following group was discussed: the American Academy of Pediatrics (AAP).

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Benefits of Early Detection and Intervention

The U.S. Preventive Services Task Force (USPSTF) found inadequate evidence on the benefits of screening and early intervention for speech and language delay and disorders in primary care settings.

The USPSTF found inadequate evidence on the effectiveness of screening in primary care settings for speech and language delay and disorders on improving speech, language, or other outcomes. Although the USPSTF found evidence that interventions improve some measures of speech and language for some children, there is inadequate evidence on the effectiveness of interventions in children detected by screening in a primary care setting.

The USPSTF found inadequate evidence on the effectiveness of interventions for speech and language delay and disorders on outcomes not specific to speech (e.g., academic achievement, behavioral competence, socioemotional development, and quality of life).

Potential Harms

Harms of Early Detection and Intervention

The U.S. Preventive Services Task Force (USPSTF) found inadequate evidence on the harms of screening in primary care settings and interventions for speech and language delay and disorders in children aged 5 years or younger.

Qualifying Statements

Qualifying Statements

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without related signs or symptoms.
- It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.
- The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.
- Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality (AHRQ) or the U.S. Department of Health and Human Services.

Implementation of the Guideline

Description of Implementation Strategy

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other

print formats for dissemination, the USPSTF will make all its products available through its Web site . The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size Guide to Clinical Preventive Services.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

Implementation Tools

Mobile Device Resources

Patient Resources

Pocket Guide/Reference Cards

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for speech and language delay and disorders in children aged 5 years or younger: U.S. Preventive Services Task Force recommendation statement. Pediatrics. 2015 Aug;136(2):e474-81. [22 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 (revised 2015 Aug)

Guideline Developer(s)

U.S. Preventive Services Task Force - Independent Expert Panel

Guideline Developer Comment

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services or its agencies.

Source(s) of Funding

The U.S. Preventive Services Task Force (USPSTF) is an independent, voluntary body. The U.S. Congress mandates that the Agency for Healthcare Research and Quality support the operations of the USPSTF.

Guideline Committee

U.S. Preventive Services Task Force (USPSTF)

Composition of Group That Authored the Guideline

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Former U.S. Preventive Services Task Force (USPSTF) members Michael L. LeFevre, MD, MSPH, and Virginia Moyer, MD also contributed to the development of this recommendation.

**Members of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to http://www.uspreventiveservicestaskforce.org/Page/Name/our-members*.

Financial Disclosures/Conflicts of Interest

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. USPSTF members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

The author has indicated he has no potential conflicts of interest and no financial relationships relevant to this article to disclose.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for speech and language delay in preschool children: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006. 10 p. [29 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Available from the Pediatrics Journal Web site.

Availability of Companion Documents

The following are available:

Evidence Reviews:

- Wallace IF, Berkman ND, Watson LR, Coyne-Beasley T, Wood CT, Cullen K, Lohr KN. Screening for speech and language delay in children 5 years old and younger: a systematic review. Pediatrics. 2015 Aug;136(2):e448-62. Available from the Pediatrics Journal Web site.
- Berkman ND, Wallace I, Watson L, Coyne-Beasley T, Cullen K, Wood C, Lohr KN. Screening for speech and language delays and disorders in children age 5 years or younger: a systematic review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 120. AHRQ Publication No. 13-05197-EF-1. Rockville (MD): Agency for Healthcare Research and Quality; 2015 Jul. 210 p. Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Barton MB et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med 2007;147:117-122.
- Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med 2007;147:871-875.
- Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205.
- U.S. Preventive Services Task Force procedure manual. AHRQ Publication No. 08-05118-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Jul. 95 p. Available from the USPSTF Web site.

The following are also available:

- Speech and language delay and disorders in children age 5 and younger: screening. Clinical summary of the U.S. Preventive Services Task Force (USPSTF) recommendation. 2015 Jul. 1 p. Available from the USPSTF Web site.
- Screening for speech and language delays and disorders in children age 5 years or younger: a systematic review. Supplemental information. Pediatrics. 2015 May;135(5):SI1-28. Available from the Pediatrics Journal Web site.
- The guide to clinical preventive services, 2014. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2014. 144 p. Available from the AHRQ Web site.

The Electronic Preventive Services Selector (ePSS) is an application designed to provide primary care clinicians and health care teams timely decision support regarding appropriate screening, counseling, and preventive services for their patients. It is based on the current, evidence-based recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

Patient Resources

The following is available:

- Screening for speech and language delay and disorders in children aged 5 years or younger. Understanding task force recommendations.

Consumer fact sheet. Rockville (MD): U.S. Preventive Services Task Force; 2015 Jul. 4 p. Available from the U.S. Preventive Services Task Force (USPSTF) Web site .

Myhealthfinder is a tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI on January 24, 2006. The information was verified by the guideline developer on February 1, 2006. This summary was updated by ECRI Institute on August 25, 2015. The updated information was verified by the guideline developer on September 30, 2015.

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